

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6553
State File No. 2024
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) <u>4 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		7259	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Lukes Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>1734 Washington Blv'd.,</u>			
3. NAME OF DECEASED (Type or Print) <u>HENRY ASHBY</u>		a. (First)		b. (Middle)		c. (Last) <u>NICKELL</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>3-1-50</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	
8. DATE OF BIRTH <u>Sept. 8, 1868.</u>		9. AGE (In years last birthday) <u>81</u>		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>23</u>		11. IF UNDER 4 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maxwell-Crouch Comm. Co. Nickells Mills, W. Va.</u>			
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>James Madison Nickells</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Washington Ford</u>		14. NAME OF HUSBAND OR WIFE <u>Eveline Wilson Nickell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. C. S. McKinney-5696 Kingsbury Blv'd.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic myocarditis</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. INTERVAL BETWEEN ONSET AND DEATH <u>2 year</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT-SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Louis</u>		21d. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Feb 24, 1950</u> , to <u>Mar 1, 1950</u> , that I last saw the deceased alive on <u>Mar 1, 1950</u> , and that death occurred at <u>10 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>William B. Ray</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>3720 Washington</u>		23c. DATE SIGNED <u>3-2-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>3-3-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>	
DATE REC'D BY LOCAL MAR 2 1950 REG.		REGISTRAR'S SIGNATURE <u>J. B. Sarate</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>C. R. Lupton & Sons-7233 Delmar Blv'd., St. Louis, Missouri.</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

7-2-2

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed

Clarence H. Murray

Licensed Embalmer No. *4011*

P. O. Address *St. Louis, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.